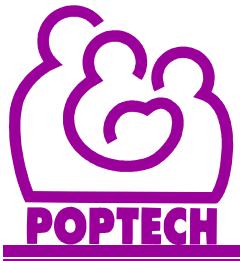

EVALUATION

OF

USAID HUMAN CAPACITY DEVELOPMENT IN HEALTH

Carol D. Brancich
Andrew Kantner

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EXECUTIVE SUMMARY

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The Population Technical Assistance Project
1101 Vermont Avenue, NW, Suite 900
Washington, DC 20005
Telephone: (202) 898-9040
Fax: (202) 898-9057
admin@poptechproject.com

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ACRONYMS

AIHA	American International Health Alliance
CA	Cooperating agency
CDC	Centers for Disease Control and Prevention
CIDA	Canadian International Development Agency
CTO	Cognizant technical officer
DFID	Department for International Development, United Kingdom
DHHS	U.S. Department of Health and Human Services
EU	European Union
GH	Bureau for Global Health
GH/HIDN	Office of Health, Infectious Diseases, and Nutrition
GH/OHA	Office of HIV/AIDS
GH/PRH	Office of Population and Reproductive Health
GH/RCS	Office of Regional and Country Support
HCD	Human capacity development
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
HR	Human resources
HRM	Human resources management
IMF	International Monetary Fund
IR	Intermediate Result
JSI	John Snow, Inc.
MAQ	Maximizing Access for Quality
MCH	Maternal and child health
MOH	Ministry of Health
NIH	National Institutes of Health
PHN	Population, health, and nutrition
PHR*plus*	Partners for Health Reform*plus* (Abt Associates, Inc.)
QAWD	Quality Assurance/Workforce Development Project, URC
SO	Strategic Objective
URC	University Research Co., LLC
USAID	United States Agency for International Development
WHO	World Health Organization

MAIN REPORT CONTENTS

EXECUTIVE SUMMARY

The purpose of this evaluation is to provide an overview of human capacity development (HCD) activities across the four main offices of the United States Agency for International Development's (USAID's) Bureau for Global Health (GH) and to recommend options for addressing future HCD needs in health service provision. This evaluation report was undertaken for GH's Task Force on Human Capacity Development.

USAID has a long and relatively successful record in various aspects of HCD for health service providers throughout the developing world. Unfortunately, previous USAID investments in HCD have been eroding (and quickly disappearing in much of Sub-Saharan Africa) in recent years. Recognition of this looming crisis has been slow to take hold within the donor community and will require aggressive remedial action if health delivery systems are not to deteriorate further.

Much of the evidence compiled for this evaluation was derived from in-person and telephone interviews. The team interviewed GH senior management staff, country coordinators, GH cognizant technical officers (CTOs), USAID population, health, and nutrition (PHN) staff residing in overseas Missions, and cooperating agency (CA) representatives. A short, online survey of HCD was sent to the same individuals that participated in the qualitative interview sessions. The survey collected information on current HCD activities, future HCD needs, and actionable short and long-term HCD priorities that might be considered for incorporation by USAID into future activities.

Results from the survey indicate that there is broad agreement that USAID should give greater emphasis to HCD in the future and that current projects could be doing more to strengthen HCD for service providers. Most respondents agreed that the per capita availability of health service providers had declined over the past decade. This view was especially marked among USAID Mission respondents in Sub-Saharan Africa.

Most survey respondents agreed that future HCD needs in service provision will be concentrated in HIV/AIDS, maternal and child health (MCH), infectious diseases, and other reproductive health services (e.g., adolescent programs and postabortion care). In the survey responses, family planning was not ranked highly as a future HCD priority area. In order to meet future demand for health care, it was noted that greater resources would need to be allocated for the training of nurse-midwives, paramedics (including various types of auxiliary workers), and community workers (including community-based fieldworkers and outreach workers). Lower priority was given to doctors, traditional nurse-midwives, and traditional healers.

The most important HCD needs typically identified by survey respondents were inservice training, staff deployment, employee incentives, conditions of service, and preservice training. Instituting better time/attendance reporting and the training of human resource specialists were ranked as the lowest priority areas.

When survey respondents were asked whether USAID could be effective in changing specific policies and practices in HCD (given host country political, regulatory, and legal environments), there was considerable skepticism concerning the Agency's ability to

significantly influence or assume responsibility for many HCD areas. For example, most respondents indicated that issues surrounding staff recruitment, staff retention, time/attendance reporting, civil service reform, and conditions of service were likely beyond USAID's ability to rectify. Respondents were more optimistic that USAID could have an important role in HCD activities that have been traditionally supported (e.g., pre and inservice training as well as the certification/accreditation of service providers), technical fields (such as workload planning), and the training of human resource managers.

Findings, conclusions, and recommendations based on interview information were organized according to four HCD classifications for action identified by the HCD task force: legal, policy, and financial; human resources management (HRM); leadership; and partnerships. Provision of service issues spans all four of these elements. Major findings under these headings are summarized below.

LEGAL, POLICY, AND FINANCIAL

Bureau Structure

The vertical organizational and appropriations funding structures of GH are seen to present problems for focused, strategically directed, HCD emphasis and/or initiatives across bureaus. A lack of open communication between offices was cited by CA, Mission, and GH respondents alike as being an obstacle in interoffice HCD areas. Because of the vertical nature of GH's structure, a variety of CAs and bilateral organizations under different programs currently work independently on HCD issues. They often do not collaborate, and this current fragmented approach is viewed as costly in terms of expended resources and time.

Recommendations

1. Advocacy by senior management levels of GH is required for undertaking HCD initiatives.

2. Establish a consensus on joint programming and funding for HCD initiatives in GH.

Salary Structures

In many country programs, limitations to host country salary structures and their companion civil service regulations were cited as almost insurmountable barriers to HCD. A number of respondents reported salary imbalances as the root causes for current service provider supply and retention problems. Antiquated personnel administration systems are reported to be in place in many countries, often deeply entrenched in the governmental culture. Performance appraisals are reported as largely nonexistent and are certainly not linked to actual quality or quantity of performance.

Recommendation

3. Salary issues should be explored in selected countries to identify potential mechanisms for improving levels and/or imbalances in service provider remuneration, including collaborating with other donors.

Essential Commodities

Supply shortages, equipment problems, and shortcomings with drugs and facilities compound the difficulties of service providers in quality of care provision. Lack of essential supplies was seen as greatly reducing providers' abilities to successfully fulfill standards of practice and also as a contributing factor to heightened worker frustration. Insufficient local financial resources were named as significant in the shortages.

Recommendation

4. As procurement requirements in GH/OHA continue to be delineated, GH should expand existing logistic management systems rather than create new ones. Coordination within GH must be strengthened using previous lessons learned (e.g., established purchasing, warehousing, and distribution systems).

HUMAN RESOURCES MANAGEMENT (HRM)

Country Strategic Plans

A number of Mission strategic plans include a Strategic Objective (SO) (e.g., Egypt), Intermediate Result (IR) (e.g., Cambodia, Kenya), or sub–IR (e.g., South Africa) that would support HCD activities. Other Missions indicated that even though no specific IR for HCD exists in their strategic plans, there would be no specific prohibition to conducting such activities. Emphasis on HCD and its system components have to date not been a priority in GH programming and funding. All Missions contacted are facing HCD needs.

Recommendations

5. In collaboration with USAID field Missions, consider undertaking HCD needs assessments in those countries with potential for success that will generate information on priority HCD needs in health.

6. Based upon the HCD needs identified through these assessments, mechanisms for incorporating HCD activities into USAID's country strategic plans should be proposed.

Integrated Broad-Scale HCD Programming

This evaluation noted that numerous and scattered HCD activities are being conducted throughout most CA projects and in bilateral agreements. However, broad-scale, integrated HCD efforts were not reported. Disjointed CA and bilateral HCD efforts are achieving output objectives, and although contributing to HCD practice improvement to

varying degrees, they are not reported to be achieving long-term sustainability in HCD. Additionally, very little if any operations research or evaluation to assess HCD approaches has been conducted.

Recommendations

7. Broad-scale, integrated HCD should adopt a systems development approach in its programming.

8. Integrated HCD should include evaluation and operations research to determine the effectiveness of different HCD approaches and the potential for replicating successful models.

Realignment of Service Provider Categories/Cadres

Due to human resource crises in numerous countries, certain provider cadres are working far beyond capacity and/or are being raided to staff crisis service areas. Others are leaving their employment. New service demands are being made of already overburdened staffs that are not necessarily the most appropriate cadre for performing the task. Respondents recognized the need for the allocation of required skill sets to nonprofessional worker cadres.

Recommendations

9. Expand and realign the categories of service providers in the health workforce (e.g., community health workers, paramedics, auxiliary health workers, pharmacists, and home care workers).

10. Redesign the required skill sets for capacity development and supervision systems needed to accommodate service provider realignment.

Training Practices

Overuse of inservice training as an exclusive means of bolstering HCD gaps was reported quite frequently. Respondents support the notion that inservice needs will always exist, especially in selected technical areas. However, they also acknowledge that invariably, a policy of using inservice training in lieu of preservice education is practiced.

Recommendation

11. Inservice training should be carefully targeted to address performance gaps in newly identified tasks being added to job requirements or to personnel as new technologies and knowledge requirements emerge.

Preservice Education and Long-Term Training

In many of the countries canvassed, current professional leadership capacity is seen as weakening and is not being readily replaced. Professional schools are underfunded, lack needed technology and updated training approaches, and are unable to meet current

health care delivery demands. Clinical expertise is reported to be lacking in very complex HIV/AIDS prevention, treatment, and care modalities, as are expert management skills to carefully balance other essential health services (e.g., child survival, immunization, population/reproductive health, and maternal/neonatal services).

The loss of GH technical support for preservice institutions, curriculum revision, and long-term training is evident in the diminishing numbers of public health professionals and upper level managers. Collaborating with U.S.–based university programs for long-term training is at a diminished level. This has resulted in reduced training stipends and health mechanisms for health personnel (e.g., trained public health professionals).

Recommendations

12. Recommit to preservice education and long-term training, with an emphasis on supporting regional and local educational and training institutions and U.S. partnering mechanisms.

13. In order to effectively address HCD policy reforms and restructuring, USAID needs to work not only with ministries of health, but also possibly with ministries of finance (for education funding), education (for nursing and medical education), and labor (for remuneration levels, incentive structures, and conditions of work).

LEADERSHIP

HCD Category/Cadre

A leadership layer of expert, well-practiced HCD leaders and managers does not appear to exist in the countries contacted, at neither central nor decentralized levels. No respondents reported broad-scale training or mentoring of HCD managers, and no one reported HCD in its preservice curriculum.

Recommendation

14. Preservice education and inservice training in HCD management should be initiated to develop an appropriate and sustainable number of managers who will address prevailing HCD issues.

Cooperating Agencies, PHN Field, and GH Staff

HCD leadership qualities and technical expertise within CA organizations were described by field and GH respondents as ranging from nonexistent to limited. CA activities in contacted countries were often seen to be repetitive in nature. The approaches were interpreted as being not customized (e.g., inservice training and supervision models) and did not address the complexity of the country's HCD problems. There currently is no sharing of HCD experience or active collaboration among organizations. Bringing together many of the GH technical expertise areas (e.g., quality assurance, performance improvement, curriculum design, training of trainers, and management and supervision) to collectively resolve service provider performance dilemmas would help ensure strengthened HCD systems supportive of various program achievements.

Recommendations

15. Increase the general awareness of HCD issues within GH and across CA organizations, and establish consultative mechanisms for sharing project experiences and identifying best practices, including those from the Maximizing Access to Quality (MAQ) Initiative, performance improvement, and quality assurance.

16. Clear language in CA annual work plans regarding the range and type of CA efforts in HCD is highly desirable. This would bolster awareness of and confidence in HCD capacities within CA organizations, throughout the CA community, and in field offices.

PARTNERSHIPS

Donor Coordination in HCD

Few respondents reported actual collaboration with other donors in the HCD sphere (e.g., the World Bank, European Union [EU], Department for International Development [DFID], or the Canadian International Development Agency [CIDA]). The potential for donor partnering is reported to be within the HCD components of personnel administration (salaries paid) and integration of human resources (HR) and health system objectives (civil service reform).

U.S. organizations were also identified as either having the presence or the potential for in-country collaboration (e.g., Centers for Disease Control and Prevention [CDC], Department of Health and Human Services [DHHS], National Institutes of Health [NIH], and U.S. foundations [Bill and Melinda Gates, William and Flora Hewlett, and David and Lucile Packard]). Several respondents were concerned by the lack of consistent, senior-level participation of GH in discussions with these organizations to assure that USAID is seen and acknowledged for its technical assistance capacity.

Recommendations

17. Host country representatives and organizations should be seen as full partners in developing and implementing any HCD initiatives.

18. Substantive liaison between USAID GH and potential partners such as the World Bank, World Health Organization (WHO), and EU would greatly increase the potential for success in HCD.

19. Participation at senior management levels with other U.S. organizations (e.g., CDC, NIH, and DHHS) is required for administrative and programmatic collaboration in health HCD efforts.

NEXT STEPS

Based upon the assessment findings and recommendations, the following concrete next steps were identified for consideration by the GH task force on HCD:

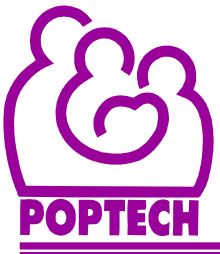
- Develop an HCD strategy that articulates HCD needs and identifies the scope and depth of priority HCD initiatives that GH may be prepared to support (both within each office and jointly). This strategy should be guided by USAID's programmatic experience, current technical capabilities, and careful assessments of the potential for success. This is an overarching recommendation for the evaluation.

- Implement an integrated HCD country initiative. This activity would address priority HCD needs in selected countries where the potential for programmatic action appears promising. The objective would be to field test various HCD initiatives in diverse country environments in order to identify successful models for action, best practices in HCD, and interventions that appear to have good potential for replicability.

- Review the status of GH's internal and contractual mechanisms for supporting long-term training in the United States.

- Evaluate the potential of professional exchange programs and collaboratives in health as effective HCD strategies.

- Position USAID to assume a more prominent global leadership role in HCD for health.



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1101 Vermont Ave., NW Suite 900 Washington, DC 20005 Phone: (202) 898-9040 Fax: (202) 898-9057 www.poptechproject.com